



The Medical Outlook SOLDIERS

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Army Medical Department Enlisted Training News

<http://das.cs.amedd.army.mil/outlook1.htm>

From the Top

Safety messages from our Chief of Staff of the Army, General Schoomaker, and Lieutenant General Kiley, Surgeon General of the Army and MEDCOM Commander, have been the focal point for leaders during the last 3 months, and rightfully so. When you look at the FY 04 statistics (see chart) on noncombat deaths, it begs the question “are we doing everything we can to eliminate or reduce these unnecessary losses?” Exercising safe measures does not mean tying ones hands by prohibiting certain and all activities; it simply means measuring the known and/or possible risks and developing a plan of action to mitigate the hazards.

We, as leaders, **must** educate our Soldiers and develop this behavior so it becomes second nature in all we do. The example used for this discussion is jumping out of airplanes. No doubt this is a risky behavior, but one that is essential to accomplishing the mission. There is a legitimate and pre-determined process that every paratrooper must go through the day of the jump before they chute up, load up, stand up, and exit an aircraft. Everything from manifest call to pre-jump training to jumping is a cognitive process that includes actions for malfunctions – water, tree, and wire landings. This is the type of culture we must create in all we do to ensure we preserve our most precious resource: “The Soldier.” Using the Soldier’s Creed as a guiding beacon is the first step in this process:

I am a Warrior and member of team. (cannot be a member if you are unavailable as a result of reckless and uncalculated behavior)

I am disciplined, physically and mentally tough. (discipline being the cornerstone of all positive results for a winning team)

I always maintain my arms, my equipment, and myself. (an unserviceable weapon or POV can lead to a disastrous outcome)

I stand ready to deploy and engage. (only if you are available to the team!)

I am an American Soldier. (a member of the most elite organization known to mankind. I am both the Offensive and Defensive line for protecting Democracy, Freedom, and all Liberties)



David A. Eddy
CSM, USAMEDCOM

Driving a POV recklessly, or any other recreational, is like playing Russian roulette with an unloaded weapon. Placed in the hands of an undisciplined person, unloaded weapons kill people every day in this country.

Situation: Johnny is addicted to cigarettes. He must smoke every hour on the hour to calm his nervous jitters. As a result of an earthquake, he is trapped in a 4’x 6’ area with a bottle of water, blanket, pack of cigarettes, and matches, along with a 50-gallon keg of dynamite. After approximately 6 hours of solitude entrapment, he can take it no longer and must smoke a cigarette to calm his nerves while waiting to be rescued. Oh, did I mention that when Johnny goes without a cigarette he goes into convulsions that, in the past, have resulted in him swallowing his tongue? Johnny has determined that to live, he **must smoke** a cigarette.

Now, a Neanderthal would just light the match with no thought of the consequences (that could explain why they are extinct), however, Johnny has evolved light years beyond his evolutionary brother and knows all actions have a consequence.

NCOPD Assignment: NCOs must discuss this scenario with their Soldiers and submit actions to mitigate the known hazards to your Regional CSM for consolidation NLT 7 Jan 05. In case you missed the point, “**Johnny will smoke!**”

Lessons Learned will be posted in the next edition of Outlook.

FY04 Army Military Fatalities

As of 21 OCT 04

Water	12
Soldiering/WPN	11
Heat/PE	15
Work	9
Other	8

Personal Injury Other, 55, 21%

Fire/Expl, 5, 2%

AVN, 12, 5%

AMV, 50, 19%

ACV, 14, 5%

POV, 130, 48%

Total: 266

FY Year End Data		
FY	Accidents	Fatalities
1999	190	186
2000	181	161
2001	173	168
2002	214	202
2003	286	260
2004	296	266
6-Yr Avg	224	207

Sedan	88
Motorcycle	23
Other	19

Army Vehicles + POV =
72% of all Fatalities

The AMEDD Enlisted Commissioning Program (AECP)

If you enjoy helping others and want to earn a degree, the Army has a program that enables you to do just that. It is the AECP and is open to all enlisted personnel regardless of MOS. Approximately 165 enlisted Soldiers are currently enrolled in colleges and universities across the country completing their Bachelor of Science Degree in Nursing (BSN).

Interested Soldiers must be able to enter a BSN program at an accredited college or university and complete their nursing degree within 24 calendar months. The program funds tuition up to \$3,000 per semester or \$2,250 per quarter. While enrolled in the program, Soldiers continue to receive enlisted pay and entitlements plus a \$1,000 annual stipend for books and other necessities. Tuition is Army funded and paid directly to the school. Upon graduation from the BSN program, Soldiers attend the AMEDD Officer Basic Course and are commissioned as Second Lieutenants in the Army Nurse Corps.

Access the Army website at www.goarmyhealthcare.com or at www.usarec.army.mil/aecp/ to review the AECP Program guidelines. **Contact:** AECP Program Manager, DSN 536-0386, (502) 626-0386, or toll free 1-800-223-3735, ext 6-0381.

Expert Field Medical Badge (EFMB) alert

The AMEDDC&S does not endorse or regulate the content of commercial EFMB study guides. Therefore, the AMEDDC&S cannot guarantee that information contained in commercial study guides is accurate or up-to-date.

The EFMB Training Control Office (TCO) recommends that personnel use AMEDDC&S Pam 350-10 and references in your preparation for the coveted EFMB badge. For more information, **contact:** SSG Chase, EFMB TCO, DSN 421-9051, (210) 295-9051, FAX (210) 221-2716, e-mail brian.chase2@cen.amedd.army.mil, or the EFMB website at www.cs.amedd/army.mil/dts/efmbhome.htm.

The Army School System (TASS) Regions Accredited

The AMEDD Center and School granted 3-year accreditation status to the following medical training battalions in TASS, effective 1 Oct 04.

Region	Battalion	Headquarters	Courses	Sates Served
C	10th BN (PN/HS)	Jacksonville, FL	91E10, 91W10, Ph 2 BNCOC, Ph 2 ANCOC	NC, SC, GA, FL, PR
F	10th BN (PN/HS)	San Antonio, TX	91W10, 91WM6, Ph 2 & 4 BNCOC Ph 2 ANCOC	NM, OK, NE, KS, IA, MO, AR, LA, TX

The TASS Regions A and D will be evaluated for renewal of accreditation during FY 05. **Contact:** TASS Training Evaluators, LTC Hirata at DSN 471-6497, (210) 221-6497 or MSG Trepkowski at DSN 471-8040, or (210) 221-8040.

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 Commander: MG George W. Weightman
 Chief, Department of Academic Support & Quality Assurance: Neta T. Lesjak
 Editor: Donald W. Aldridge

LESSONS LEARNED

After Action Reports

The information contained in the following After Action Reports includes the views and opinions of the authors and does not necessarily reflect those of the AMEDDC&S or the Army Medical Department.

After Action Report on Deployment to Iraq: Role of the Combat Support Hospital

1. **Background:** I was deployed in support of Operation Iraqi Freedom from 19 October 2003 until 24 January 2004. For the first 2 months I served as a General Surgeon with the 945th Forward Surgical Team (FST) at Rifles Base, Al Asad Airbase, and for the last month, I was assigned as a general surgeon with the 21st Combat Support Hospital (CSH) South at LSA Anaconda, Balad, Iraq. The 945th FST is an Army Reserve unit based at Fort Snelling, MN and the 21st CSH is an active duty unit based at Fort Hood, TX. Both served as part of the 30th Medical Brigade. The 21st CSH, while I was deployed with it, was divided into two slices, the larger slice at LSA Anaconda, in Balad, and a smaller slice in Mosul. The commander remained with the main slice in Balad and the DCCS became the “commander” of the slice in Mosul. Each slice was capable of caring for about 40 patients. As a faculty member of a “traveling trauma symposium,” I was able to visit the 30th Med BDE (Baghdad), the 28th CSH North (Tikrit) and South (Baghdad), the 21st CSH North, and the 728th FST (FOB St Mere). I interviewed leaders and providers of each of these units as well as leaders of several other FSTs (936th, 801st, and 1st) in preparing this report.

2. **Size:** Ability to split CSH’s in two slices works well. Both major CSH’s in theatre are split. It works so well that one should consider making the generic CSH half the current size. This would make deployment easier, quicker, with less of a logistic tail. Even divided into two slices, each portion of the CSH is large, heavy, occupies a lot of ground, and would take a long time to take down and move to a new location. These are not mobile hospitals by any stretch of the imagination. If a larger hospital is needed, the small units could be brought together as a medical task force. There is some minor decrement in function caused by dividing resources such as X-ray, lab, and food service. Command structure is duplicated at each location. Divided CSHs are separate units “in fact.” Smaller independent hospitals would make Command and Control easier than a divided CSH with each slice at distant locations. The 21st CSH North had 44 beds and the 21st CSH South had 84 beds. The 21st CSH South had 76 patients on one occasion but generally ran a census below 40 patients. The CSH North peak capacity was 30 patients with average census much less. With early evacuation, even surge mass casualty situations have been relatively easily taken care of by the split units using triage and other practiced skills. The CSHs have too many providers – leads to boredom and dissatisfaction.

3. Deployment Issues:

a. *Engineering support during deployment:* Since the CSH is relatively immobile, it would greatly benefit from better Engineering Support prior to and during set up. Site grading and preparation to permit proper drainage prior to establishing the hospital would improve sanitation and living conditions as well as decrease the problems of water flowing through patient care areas during heavy rains. Once the hospital is established on the ground, it is very difficult to secondarily go back and improve site grading and drainage. If a CSH is only going to be in an area for a short time before a planned move, this may not be critical. Most often, a CSH is deployed at a single location for a very long period.

b. *Lift capacity:* CSHs must displace by echelons or get corps transportation assets to displace in one lift. These corps assets are not readily available during the early phases of a combat operation. The M1022/M1022A1 Dolly sets for carrying MILVANs and ISO shelters did not work for long hauls over rough terrain. They frequently broke and neither replacement Dollys nor repair parts were available. If we must continue to rely on Corps transportation assets anyway, a better solution than Dollys is to transport the MILVANs and ISO shelters using Heavy Expanded Mobile Tactical Trucks with the Palletized Loading System, the Load and Handling System

(LHS), or the Family of Medium Tactical Vehicles with the LHS. These trucks may be too expensive and complex to be organic assets to the CSH, but they are ideal for moving and placing the CSHs initial load of equipment.

4. PROFIS: The professional filler system did not work smoothly and has some shortcomings. The personnel management system operated by MEDCOM does not seem to know the actual personnel needs of the units in theater. Unexpected replacement surgeons arrived at units before the redeployment dates of physicians already on station. The relieved physicians were not allowed to return to CONUS and the extra personnel are now not available for later deployment echelons where shortages exist. It is a very wasteful and inefficient use of professional resources. The majority of the general surgeons who deployed, as well as the surgical subspecialists deploying as general surgeons, have little recent trauma experience. We need to practice and train as we fight which means emphasizing rotations at civilian trauma centers for ALL surgeons and aligning our major military medical centers with civilian trauma networks. The use of surgical subspecialists such as gynecologists, urologists, thoracic surgeons, and plastic surgeons can only be justified if they spend some time rotating on general surgery services in peacetime to maintain these critical skills. Many PROFIS personnel never train with their units in peacetime. This problem, as well as cross leveling, meant that many personnel had little knowledge or understanding of their wartime units and jobs and met for the very first time when they arrived at the mobilization station. Varying lengths of deployments for augmentees vs PROFIS providers, and for active duty vs reservists, caused morale problems and some angst. (Unit members should train together in peacetime and with rare exceptions, deploy together as a group and redeploy at the same time. More frequent 6 month deployments would be better tolerated by professional staff than 1 year deployments because of concerns about loss of skills and not practicing one's primary specialty.)

5. Equipment: At the CSH level, there were certain pieces of equipment which would have been very useful. Some of these items were available at CSHs and Evacuation Hospitals during Operation Desert Storm and had been removed from the sets. These included C-arm fluoroscopy units and Cell savers. The Bair Hugger patient warming system has been identified as a critical item and has been purchased separately, but is still not universally available at all CSHs. Modern trauma care requires good imaging technologies, particularly for neurosurgery, but also for maxillofacial surgery, ophthalmology, and orthopedics. Each CSH should have a CT scanner and there probably should be at least one MRI unit available somewhere in the theater so that Soldiers requiring an MRI scan for orthopedic or other reasons do not have to be evacuated out of theater solely to obtain this study. Generators continue to be a problem. The CSHs do not have enough generators for all of their needs and for backup. The 100KW generators could not handle the high heat of the Iraqi summer, even when shaded by temporary roofs. The Rough Terrain Cargo Handlers are a success story in material handling. Available as a Corps asset, they are very effective in moving MILVANS and ISO shelters about and for positioning them once they arrive on-site.

6. Laboratory: The lack of microbiology capability is a huge shortcoming, particularly for the care of Enemy Prisoners of War (EPWs) and civilians who are not evacuated. The treatment of infectious disease problems without being able to obtain a culture cannot be justified. "Shotgun" antibiotic therapy may be all right for prophylaxis, but it is not acceptable as standard treatment for established infections.

7. Treatment of EPWs and noncombatants: We need to get over the doctrinal idea that our TOE medical units do not treat civilians, women, and children. Since before Vietnam, we have always done so – prepare, staff, and supply for it! Many of the patients in this conflict are Iraqi, both EPW and innocent civilians. Patients not only include adults but indigenous children. Long-term care of Iraqis, both EPW and civilians, is problematic since they cannot necessarily be transferred to civilian institutions for long-term convalescence, rehabilitation, prosthetic fitting, etc. The CSH is not equipped for long-term and/or chronic care.

8. Prolonged care in theater: Long-term intensive care, although better than that available in civilian institutions, is difficult because of the lack of the proper types of ventilators, as well as the lack of some laboratory support, most notably the ability to obtain bacteriological cultures and sensitivities.

9. Communications: CSHs have limited numbers of phone lines and signal assets. It remains difficult to contact other providers at both higher and lower echelons of care. E-mail in theater was a tremendous help in this regard, but e-mail is not available universally or at all echelons of care. Patient evacuation from the CSH works all right with the Air Force due to their embedded evacuation personnel. Incoming emergency helicopter evacuation is more problematic because of limited communication between medical personnel on the helicopter and medical personnel at the CSH, particularly in the emergency room.

10. **Medical Logistics:** The 21st CSH South was located directly across the street from a Medical Logistics BN, and still, resupply of medical items was problematic. The Medical Logistics system cannot find inventory even when their inventory tracking computers show the items are in theater. I understand that, in the Corps area, there was a problem with storage of Class VIII material on pallets in the open exposed to heat, dust, and water. This led to waste and the necessary disposal of large amounts of damaged material. The order to ship time was 30 days early in the conflict and is 12 to 14 days now, which is still too long. Medical logistics remains a difficult problem.

11. Conclusions and Recommendations:

a. In the grand scheme of things, the problems identified in this report are relatively minor. The deployable medical system works and our doctrine works, but with refinement of the system, they can work even better. Well-trained and dedicated personnel at all levels have provided outstanding care to our Soldiers. Allowing them to be flexible has enabled them to overcome most obstacles. The outstanding mortality and morbidity statistics from this conflict attest to the excellent care we are providing, but we must not rest on our laurels. It can be even better.

b. Doctrinally, the CSH should be a much smaller unit – it should probably be cut in half in size, equipment, and staffing. In the rare situation that operational requirements would dictate a unit with greater than 50 bed capacity, two CSHs could be located near one another. It is probably easier to collocate units than to divide a unit. There is no savings in staff by dividing the CSH since each “slice” essentially duplicates the staff and administration and some parts of the CSH are not easily separated into two sections. A smaller CSH would be easier and quicker to deploy into theater and would be relatively more mobile.

c. FSTs should be an organic asset of the CSH to give it flexibility to support mobile and quickly developing operations. Better coordination between combat commanders, the Medical BDE, and the CSH commanders, would enable the most effective tailoring of all medical assets, including CSHs and their organic FSTs to meet operational medical requirements.

d. Care of EPWs, local civilian nationals, and even children, has been a part of every medical operation since WWII. It is unlikely that we will ever conduct an operation without caring for these categories of patients, so our doctrine should recognize and plan for the obvious. At least limited capability should be added to the CSH TOE to provide care for children and civilians. Pediatric Augmentation Teams should be established to provide even greater level pediatric support for stability operations.

e. A small number of military hospitals should be created (call them evacuation hospitals or field hospitals) to take care of the more chronic needs of EPWs and civilians who cannot be evacuated out of theater. This type of unit need not be very mobile and should provide Occupational Therapy, Physical Therapy, and more long term care than that which is available or appropriate at a CSH.

f. Available communications technology currently exists including tactical satellite telephones, in theater cell phone communication, and Harris HF radio, which could ameliorate many of the communication problems between units and providers at different echelons of care.

12. Implications for Army Medicine as a Whole:

a. We are not training and practicing in civilian life in the specialties needed to go to war. With limited training dollars and residency slots, we need to realign our peacetime Army operations with our go to war mission. Army residency programs at military medical centers should emphasize the specialties that are critical for wartime deployment: general surgery, trauma critical care, orthopedics, anesthesia, emergency medicine, primary care, general medicine, infectious disease, preventive medicine, general pediatrics, gynecology and obstetrics, psychiatry, ophthalmology, and neurosurgery. Training in specialties and subspecialties not critical for combat should be de-emphasized, and where needed, should be provided by sending trainees to civilian institutions or hiring contract physicians to supply the peacetime services in our Medical Centers. What we cannot easily hire civilian providers to do is to go to war, and this should be our emphasis. Examples of specialties to be de-emphasized include: CT surgery, cardiology, endocrinology, Moh's dermatologic surgery, endocrinology, radiation therapy, and oncology.

b. All designated Medical Centers should be aligned with civilian trauma systems so that we train as we work. Paying for some nonreimbursed civilian trauma care is a good investment in training. Use the model of Brooke Army Medical Center and Wilford Hall Medical Center. Medical Centers that are unable to accomplish this should be redesignated as MEDDACs and have their training programs transferred to centers that emphasize trauma care. It specifically makes no sense to train military surgeons in environments where trauma is not seen or cared for on a daily basis.

c. Providers need to care for patients in peacetime to prepare for war. We need to realign the political, reimbursement, and administrative processes to see that peacetime military doctors are in locales where they can have a robust practice in the “go to war” essential specialties. In some cases, this may entail detailing them to VA, university, or other institutions.

d. The Army Reserve model works well. Physicians practice civilian medicine all week and then on weekends and for 2 weeks each year they devote themselves to military matters. Surprisingly, our active duty AMEDD is less prepared to deploy than many of our reserve/guard medical units. All AMEDD personnel should be required to serve with their PROFIS unit for a minimum 2-week annual training, preferably in a field environment. Non-PROFIS personnel should also be required to attend some sort of 2-week medical field training exercise as well. These field experiences should be robust, worthwhile, and emphasize field Medical care and not serve as a replacement for common task training. We need to train as we fight!

13. Research and Development

a. In my opinion, we are wasting a lot of effort on “gee whiz” types of things. The important research items tend to come from bread and butter clinical care applications that are then applied to the field. Warfighter Physiological Status Monitoring is an example of a huge resource spent on a “gee whiz” project of limited application. Continuous monitoring of every Soldier’s blood pressure or pulse is unnecessary to determine if he or she is dead or alive is a waste. Just lean over and ask him or his buddies. A better use of resources is to field squad level radios with adequate range which will enable medical communications between the medic and higher medical facilities, either the FST or CSH, so they can collaborate or communicate in order to give the medic advice, and prepare the hospital to receive the evacuee. The working model should be along the lines of an EMT in an ambulance communicating with an ER physician.

b. Another key to changing how we operate on the battlefield is better, smaller, more portable imaging technology. Portable ultrasound has helped but there is more that we can do including robust portable fluoro equipment. The i-stat has helped with lab tests, but we still need field microbiology to rapidly rule out biowarfare and more standard microbial agents. Very importantly, we need better technology to decontaminate and treat patients in a contaminated chemical environment. The current doctrinal solutions are too cumbersome and not realistic.

c. Lastly, we must continue to improve evacuation techniques and capabilities. The Critical Care Transport Teams have proven their worth in low intensity situations, but their resources would be overwhelmed with mass casualties. The answer may be better surgical LSTATs or PODs, ECMO or circulatory assist devices applied in the field, a larger flying ICU, or some new innovation. Whatever the ultimate solution, we have not solved the problem of evacuation of large-scale numbers of critically ill patients.

(David J Cohen, COL, Senior Clinical Consultant, 10 Feb 04)

New AMEDDC&S Knowledge Management Website

The Enterprise Consultancy (EC) and Knowledge Exchange (KE) websites have merged to form the new AMEDDC&S Knowledge Management (AKM) website. Former users of EC and KE will find that their new business processes will continue with minimal interruption.

The new site is customer-driven and managed by the Knowledge Management Division, Knowledge Management and Lessons Learned Directorate, Assistant Commander for Force Integration (ACFI). You are invited to tour AKM and consider how you might utilize one or more of these internet-based resources offered:

- Individualized problem-solving assistance
- Internet-based discussions
- Centralized document sharing and management
- Web space for managing content
- Web-based survey tool
- Training resources
- Decision Support Center
- AMEDD links and activities
- Balanced Scorecard information

You can visit by going to the AMEDDC&S site at <http://www.cs.amedd.army.mil> and following the AKM link, or by going to <https://akm.amedd.army.mil/>.

Contact: Ms. Waldman, Knowledge Management Division, Knowledge Management and Lessons Learned Directorate, ACFI, DSN 471-6677 or (210) 221-6677.

The Physician Assistant Program

The Insterservice Physician Assistant Program is a 2-year officer producing school with a year of didactics at Fort Sam Houston and a year of clinical rotations at a MEDDAC. Graduates are awarded a Master's Degree from the University of Nebraska, and enlisted and warrant officer graduates are commissioned as 2LTs in the Army Medical Specialist Corps, and awarded AOC 65D. For course prerequisites, access the ATRRS website at <https://attrrs.army.mil>.

The deadline to apply is 30 Apr annually and the board reviews eligible applications in Jul. Results are published in late Aug on the Human Resources Command site. All application information is found at the following annual message site: <http://healthcare.goarmy.com/docs/paqual3.htm>.

For Active Army, **contact:** Program Manager, DSN 536-0386, (502) 626-0386, or 1-800-223-3735 – ext 6-0386. For U.S. Army Reserve personnel, **contact:** SSG Pope, DSN 892-0444 or (314) 592-0444. For ARNG applications, **contact:** CW3 White, DSN 327-7306, (703) 607-7306, or e-mail doug.white@ngb.army.mil.

New site for Mission Training Plans (MTPs)

The General Dennis J. Reimer Training and Doctrine Digital Library (RDL), home of 49 AMEDD MTPs, has migrated to a new site. The MTP provides the foundation for unit training strategies and describes what and how to train. To access these electronic publications, use your Army Knowledge Online (AKO) username and password at www.train.army.mil. Select "RDL Services" and enter type and school for the desired publication and submit.

You can also access the web page from "My Training" under "Self-Service" on AKO at <http://www.army.mil>. Select "Soldier's Training Home Page" under "Training Knowledge Online." Request an AKO password at www.us.army.mil if required. **Contact:** Ms. Garza, Department of Training Support, ARTEP Branch, DSN 471-2672, (210) 221-2672, or e-mail crescenciana.m.garza@amedd.army.mil.

Correspondence Courses on Internet

You can enroll in medical correspondence courses at the following website: <https://www.atrrs.army.mil>. A course catalog is available in the upper right corner to review courses and their prerequisites. Medical correspondence courses are found under school code 555. Copy the exact number and course title, return to the ATRRS homepage, and submit an application. Scroll down the right side under channels for SELF-DEVELOPMENT, click on it for the application form, and follow on-screen instructions. If submitted correctly, you will receive an e-mail message that materials will be mailed within 2 weeks. This message is from ATRRS, not the AMEDDC&S. Soldiers enrolled in a medical course will receive a notice of enrollment from the Nonresident Instruction Section, Fort Sam Houston, TX.

Applications submitted through ATRRS build a Soldier's academic record as the correspondence courses are filed with all other formal training under completions and noncompletions. **NOTE:** A central e-mail address is available to communicate with the AMEDD Correspondence Course Program. The web address, monitored daily, is accp@amedd.army.mil and links correspondence course students to personnel who can assist them with problems or concerns about enrollment. **Contact:** Nonresident Instruction Section, 1-800-344-2380 (toll free).

Officer Candidate School (OCS)

Deciding to attend OCS is a highly competitive option not available to everyone. Candidates must have a 4-year college degree and meet other requirements such as height, weight, and medical standards. Those selected must complete Basic Combat Training before attending OCS.

During the 14-week OCS course, candidates are trained in Army leadership skills. After completing OCS, officers attend the Officer Basic Course (OBC) for their designated career field and receive classroom and hands-on training in career-specific skills. New OBC graduates generally begin their Army management careers as platoon leaders in the rank of Second or First Lieutenant and are stationed at installations around the world.

For questions about Eligibility Criteria, Officer Branching Assignments, and availability of class dates, **contact:** Mr. Rolland, Department of Army OCS/ROTC Management, e-mail rollanda@hoffman.army.mil or call DSN 221-3756 or 1-800-654-7298. For application details, go to website http://www.infantry.army.mil/ocs/content/apply_to_OCS.htm. If you still have questions, **contact:** USAREC HQ at (502) 626-0467.

Professional Postgraduate Short Course Program FY 05 Projected Courses

Title	Crs Number	Dates	Location	Proj Officer	Phone
Med Log Enl Short Crs	300-A0710	21-25 Mar 05	San Antonio, TX	SGM Santos	DSN 471-6264
Chief & Sr Clinical NCO	300-A0712	24-27 Apr 05	San Antonio, TX	SGM Robinson	DSN 471-6603
Enl Clinical Spt Short Crs	300-A0716	12-16 Jun 05	San Antonio, TX	SFC Manzanet	DSN 471-8158
MEDCOM Sr NCO Short Crs	340-A0715	27 Jun - 01 Jul 05	San Antonio, TX	SGM Dingman	DSN 471-6710
Plns, Ops & Tng Short Crs	300-A0706	27 Jun - 01 Jul 05	San Antonio, TX	SGM Reeves	DSN 761-7001
Officer/Enlisted Short Courses					
Armd Forces Scientists Med Lab	6H-300/A0412	13-18 Mar 05	Jacksonville, FL	MAJ Tenney	DSN 471-7132
Vet Lab Crs	6G-300/A0301	21-25 Mar 05	San Antonio, TX	COL Huck	(210) 295-4604

For course prerequisites, access the ATRRS website at <http://atrrs.army.mil>. For more information, contact the Project Officer above or SFC Gutierrez, Senior Enlisted Advisor, Department of Health Education and Training, DSN 471-0144 or (210) 221-0144.